**BEFORE THE**
**DIVISION OF MEDICAL QUALITY**
**MEDICAL BOARD OF CALIFORNIA**
**DEPARTMENT OF CONSUMER AFFAIRS**
**STATE OF CALIFORNIA**

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| In the Matter of the Accusation Against: | ) | |
| | ) | Case No: 11-1999-97648 |
| ANTONIO A. ROMERO, M.D. | ) | |
| | ) | OAH No: L2000110214 |
| Physician and Surgeon's Certificate No: A-34298 | ) | |
| Respondent. | ) | |

## DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby accepted and adopted by the Division of Medical Quality of the Medical Board of California, as its Decision in the above entitled matter.

This Decision shall become effective at 5:00 p.m. on February 27, 2004.

DATED January 28, 2004

DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA

Ronald Wender, M.D.
Chair, Panel B
Division of Medical Quality

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| In the Matter of the Accusation Against:<br><br>ANTONIO A. ROMERO, M.D.<br>9321 Florence Ave.<br>Downey, CA 90240<br><br>Physician and Surgeon's Certificate No. A34298<br><br>Respondent. | Case No. 11-1999-97648<br>OAH No. L2000110214 |

# PROPOSED DECISION

This matter came on regularly for hearing before Ralph B. Dash, Administrative Law Judge with the Office of Administrative Hearings, on January 7, 8, 9, 10 11, 14 and 17, 2002 and August 4, 5, 6 and 7, 2003, at Los Angeles, California.

Amy Fan, Deputy Attorney General, represented Complainant during the 2002 portion of the proceedings. Diane M. L. Tan, Deputy Attorney General, represented Complainant for the remainder of the proceedings.

Charles J. Norek, Attorney at Law, represented Respondent during the 2002 portion of the proceedings. Geoffrey T. Moore, Attorney at Law, represented Respondent for the remainder of the proceedings.

The record was left open for the receipt of additional evidence and the filing of closing and reply briefs. On August 29, 2003, Ms. Tan submitted certified copies of billing records regarding patient S.R. These records were marked as Exhibit 47 and admitted into evidence. The closing and reply briefs were duly received and the matter was deemed submitted on December 15, 2003.

Oral and documentary evidence having been received and the matter submitted, the Administrative Law Judge makes the following Proposed Decision.

* * * * *

FINDINGS OF FACT

1. Ron Joseph made the First Amended Accusation in his official capacity as Executive Director of the Medical Board of California ("Board").

2. On August 13, 1979, the Board issued Physician and Surgeon's Certificate Number A34298 to Respondent Antonio A. Romero (Romero). At all times relevant hereto, said Certificate was and now is in full force and effect.

3. In making this Proposed Decision, the Administrative Law Judge is guided by the following:

With respect to determination of credibility: "On the cold record a witness may be clear, concise, direct, unimpeached, uncontradicted -- but on a face to face evaluation, so exude insincerity as to render his credibility factor nil. Another witness may fumble, bumble, be unsure, uncertain, contradict himself, and on the basis of a written transcript be hardly worthy of belief. But one who sees, hears and observes him may be convinced of his honesty, his integrity, his reliability." ( *Meiner* v. *Ford Motor Co.* (1971) 17 Cal.App.3d 127, 140 [94 Cal.Rptr. 702].) The trier of fact may "accept part of the testimony of a witness and reject another part even though the latter contradicts the part accepted." (*Stevens v. Parke Davis & Co.* (1973) 9 Cal. 3d 51, 67.) The trier of fact may also "reject part of the testimony of a witness, though not directly contradicted, and combine the accepted portions with bits of testimony or inferences from the testimony of other witnesses thus weaving a cloth of truth out of selected material." (*Id.*, at 67-68, quoting from *Neverov v. Caldwell* (1958) 161 Cal. App. 2d 762, 767.)Further, the fact finder may reject the testimony of a witness, even an expert, although not contradicted. (*Foreman & Clark Corp. v. Fallon* (1971) 3 Cal. 3d 875, 890.) And, the testimony of "one credible witness may constitute substantial evidence", including a single expert witness. (*Kearl v. Board of Medical Quality Assurance, supra*, 189 Cal. App. 3d at 1052.) [But] The rejection of testimony does not create evidence contrary to that which is deemed untrustworthy. Disbelief does not create affirmative evidence to the contrary of that which is discarded. The fact that a jury may disbelieve the testimony of a witness who testifies to the negative of an issue does not of itself furnish any evidence in support of the affirmative of that issue, and does not warrant a finding in the affirmative thereof unless there is other evidence in the case to support such affirmative. (*Hutchinson v. Contractors' State License Bd* (1956) 143 Cal. App. 2d 628, 632-633, quoting *Marovich v. Central California Traction Co.* 191 Cal. 295, 304.)

With respect to standard of proof: The standard of proof which must be met to establish the charging allegations herein is "clear and convincing" evidence. *Ettinger v. Board of Medical Quality Assurance,* 135 Cal.App.3d 853 (1982). This means the burden rests with Complainant to offer proof that is clear, explicit and unequivocal--so clear as to leave no substantial doubt and sufficiently strong to command the unhesitating assent of

every reasonable mind. *In re Marriage of Weaver*, 224 Cal.App.3d 478 (1990). The Medical Practice Act[1], under which these proceedings were brought, does not define "gross negligence" or "incompetence". The Court of Appeal defined "gross negligence" in *Kearl v. Board of Medical Quality Assurance,* (1986) 189 Cal. App. 3d 1040 as follows: "Gross negligence is 'the want of even scant care *or* an extreme departure from the ordinary standard of conduct.'" (*Cooper v. Board of Medical Examiners* (1975) 49 Cal.App.3d 931, 941 [123 Cal.Rptr.[page 1053] 563], quoting from *Van Meter v. Bent Construction Co.* (1956) 46 Cal.2d 588, 594 [297 Cal.Rptr. 644].) The use of the disjunctive in the definition indicates alternative elements of gross negligence—both need not be present before gross negligence will be found. (*Gore v. Board of Medical Quality Assurance* (1980) 110 Cal.App.3d 184, 196-197 [167 Cal.Rptr. 881].)"[2] The terms "negligent" and "incompetent" are not synonymous. Incompetence has been defined as a "general lack of present ability to perform a given duty." (See, *Pollak v. Kinder*, 1978) 85 Cal. App. 3d 833, 837-838, where the court distinguished negligence from incompetence when it stated, "[A] licensee may be competent or capable of performing a given duty but negligent in performing that duty." (*Ibid.*) 837; *see also James v. Bd. of Dental Examiners* (1985) 172 Cal. App. 3d 1096, at 1109 where the court held: "Incompetence generally is defined as a lack of knowledge or ability in the discharge of professional obligations."

With respect to standard of care: The standard of care for a given profession is a question of fact, and in most circumstances must be proven through expert witnesses. *(Flowers v. Torrance Memorial Hospital Medical Center* (1994) 8 Cal. 4th 992, 997-998, 1001; *Alef v. Alta Bates Hospital* (1992) 5 Cal. App. 4th 208, 215; *see* 6 B. Witkin, *Summary of California Law* (9th Ed.), *Torts*, sections 749, 750, and 774.) However, in some cases the standard may be defined by a statute or regulation. California law defines "standard of care" as the use of that reasonable degree of skill, care, and knowledge ordinarily possessed and exercised by members of the profession under similar circumstances, at or about the time of the incidents in question. (*Flowers*, supra.)

4. This matter involves Respondent's care and treatment of four patients. Evidence presented at trial was almost exclusively the domain of medical experts, one for each side. Not surprisingly, the expert's opinions differed on many issues; however, they did agree on a number of points. Both experts were well versed, highly competent practitioners. Neither expert can be said to be more "credible" than the other, although Complainant's expert testified in far greater detail on many of the issues raised.[3] Respondent's expert spent a

[1] Business and Professions Code Sections 2000 through 2521.

[2] The disjunctive definition set forth in *Gore* was also followed in *Yellen v. Bd. of Med. Quality Assurance* (1985) 174 Cal. App. 3d 1040, 1058.

[3] Respondent contends Complainant's expert was more advocate than expert. It is true he did, at times, defend a position he had taken when the better, and more obvious, course he should have taken was to admit he erred. This detracted from his credibility only to the extent his opinions were not supported by the medical records. The same is true for Respondent's expert; he too sometimes acted as an "advocate". This is not unusual as experts are often passionate about their opinions. Similarly, Respondent's continued assertion that he is being "persecuted" for past conduct is not found to adversely reflect on his credibility. He really does feel persecuted. However, Respondent's manner and demeanor while testifying, coupled with what appeared to be his propensity for giving somewhat convoluted and hesitant answers, did reflect adversely on him. In this regard it should be noted that some of

portion of one afternoon testifying, as opposed to several grueling days for Complainant's expert. Some of his testimony was quite specific, while portions of his testimony was "generic".[4] The experts did agree that Respondent's admitted "modifications" made to patient records was "inappropriate".[5] The following Findings are made based on the completeness and accuracy of the expert testimony when weighed in conjunction with a thorough review of the medical records.

**PATIENT S.M.**

5. Patient S.M., a 2½ year old healthy male with normal respiratory rates, had his first office visit with Respondent on September 26, 1997. The chief complaints included nausea, vomiting, loose bowel movements, cough, and chest congestion. Examination of the patient revealed a slight fever of 99.8 degrees, inflammation of the pharynx, and some abdominal tenderness. Respondent's diagnostic tests performed included throat and stool cultures. The treatment consisted of medication such as Loperamide liquid for diarrhea, Rondec syrup for cough, and Septra suspension, an antibiotic.

6. Respondent saw S.M. 13 times over a period of 17 months. The patient was repeatedly diagnosed with acute bronchitis. Respondent's other diagnoses included acute pharyngitis, acute gastroenteritis, anemia, acute rhinitis, acute otitis media, acute pneumonitis or pneumonitis, body weakness, inhalant allergy, acute allergic rhinitis, acute tonsillitis, allergic dermatitis, impetigo, acute cystitis, and possible tuberculosis. Respondent repeatedly prescribed oral antibiotics for various diagnoses. Respondent treated the patient with an injection of Ampicillin, followed by an oral course of antibiotics on at least five visits, and an injection of Ampicillin on two other occasions. On several of the visits, some sort of diagnostic study was ordered, such as a throat culture, serum hemoglobin or chest X-ray.

7. At the hearing of this matter, Respondent's original chart for S.M. (as well as the charts for the other patients) was examined and compared with copies of the charts Respondent had first sent as part of insurance claims, and later sent to the Board as part of its investigation. Respondent was criticized for using a form, or template, to record his findings. This criticism was not well taken. While the template may be somewhat cramped, and while Respondent might have used them "by rote", use of the form in and of itself was not below the standard of practice. However, Respondent altered or modified the medical records of patient S.M. (as well as the other patients) in numerous places. The "modifications" were made <u>after</u> the Board subpoenaed the records, and differ from the records Respondent had

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Respondent's testimony, particularly on cross-examination, had the air of spontaneous fabrication. This was particularly evident during his attempts to explain his rationale for making changes to his charts, discussed more fully below. Respondent offered no evidence, in the form of character witnesses, to attest to his honesty, integrity or skills as a physician.

[4] For example, Respondent's expert testified that he had reviewed the records of all four patients, and found no violation of the standard of care regarding Respondent's use of antibiotics. This general testimony was followed with some specifics but did not rebut the majority of the testimony of Complainant's expert.

[5] They also agreed that any changes made to the chart, discussed infra, should make it clear that a change or late entry was made and that "whiteout" should not be used.

previously submitted for insurance claims. Many of the changes were inconsequential, but some were significant. Respondent failed to note the date of the changes, and also failed to initial them. Some of the changes were found to be accurate "corrections", based on information that had been previously charted. Other changes were made without explanation or "back-up", and appeared to be inserted to make Respondent's records "look good" for the Board.[6]

8. On Respondent's chart regarding the February 25, 1998 visit, the patient's temperature was whited-out and 100.2 degrees was written over it and an entire line under "RX & Plan" were whited-out and "Septra suspension B.I.D." was written over it without any justification noted. On Respondent's chart of the April 10, 1998 visit, part of the record is whited out, "Augmentin" is written over, and part of another prescription is also whited out. On that same chart page, a blood pressure reading was added. At one point, Respondent stated he came up with the blood pressure figures by taking 'an average' of other readings. Respondent also added symptoms, notations and drawings to the original of the medical records. On the original April 22, 1998 chart page, the handwriting of the patient's name, the date and vital signs are in a different handwriting than on the medical record sent to the insurance company. In addition, blood pressure was added to the original of the record, the pulse was changed from 62 to 68, and the temperature changed from 100.3 to 99.2. The symptoms are different in the two medical records. "Bone and joint paints" are listed in one set of records and not in the other. In the original of the medical record, under physical examination, there is a notation of "no exudates", which is not in the copy provided to the insurance company. Pulmonary ENT referrals and throat cultures were also added to the original and were not noted in the record sent to the insurance company.

9. On the original of Respondent's chart of the December 28, 1998 visit, "39 inches" has been written over a white-out under height, which is the exact same height the patient was on April 22, 1998. One week later, the notation for height is 42 inches, which is an indication that the child had grown three inches in one week! In addition, the original of Respondent's medical record of the January 11, 1999 visit had been completely re-written. Notations of blood pressure and drug allergies were added to the original of the medical record. The respiratory rate is 18 on the original medical record, and 19 on the copy sent to the insurance company. Tuberculosis was indicated on the copy of the record provided to the insurance company, but was indicated as "tuberculosis (?)" on the original of the medical record. In the "original" chart page for this date, it was noted that the patient was advised to control all dusts, allergens and birds[7], he was prescribed the antihistamine Zyrtec, and he was referred to an ENT and an allergist. None of this information was contained in the copy of the record previously sent to the insurance company. On the original chart of the February 1, 1999, visit blood pressure of 92/60 was added, the child was noted to be 62 inches (which meant that he had grown 20 inches in two weeks), and information regarding allergies, nasal

[6] The experts agreed white-out should not be used to make chart changes. The proper method is to draw a line through the item to be changed, leaving the same legible, then making the change and initialling it. The change should also be dated. The same follows for additions to charts. The addition should be initialled and dated.

[7] That is, exposure to birds; the child's father raised pigeons.

swelling and sinus pains had been added. The dosage of Zithromycin was whited out and rewritten at 200 milligrams.

10. Respondent administered injections of Ampicillin to the patient without documented medical rationale or justification. An injection of Ampicillin given on December 1, 1997, was inappropriate treatment and was not indicated. The prescription of the oral antibiotic Augmentin was appropriate to resolve the problem. Injections of Ampicillin on February 11, 1998, April 10, 1998, April 22, 1998, January 11, 1999 and January 15, 1999 were inappropriate and not medically indicated. Respondent offered a somewhat "generic" explanation for his overuse of parenteral antibiotics on S.M. as well as other patients. He explained that in the socio-economic culture of his patient population (low-income, mostly Hispanic), a visit to the doctor was not deemed complete unless one "received a shot", and since the shots did no harm, he would administer them. Respondent put patient requests ahead of sound medical practice. Respondent could have done much better in serving his patients by explaining why the shots were not necessary. On December 29, 1997, Respondent ordered a throat culture for the third time since S.M.'s initial visit on September 26, 1997. This was unnecessary and not medically justified. Postural drainage of S.M on December 1, 1997, February 25, 1998, and April 10, 1998, were inappropriate. [8]

**PATIENT L.M.**

11. Patient L.M., a 27 year old female, had her first office visit with Respondent on September 2, 1997. Besides having a history of depression, for which she was taking an antidepressant, she was apparently healthy. On that initial visit, L.M. complained of depression, being tired or weak, and a fungal infection of her feet. Respondent's diagnoses of the patient included depression, body weakness, tinea ungium and bacteruria. The diagnostic studies included a urinalysis and blood chemistries. She was treated with a change in antidepressant. Respondent's records show he saw this patient 13 times over the next 16 months.

12. As with the records for S.M., Respondent altered or modified, without adequate explanation, the medical records of L.M. in areas such as examination, findings and treatment plans. On the original chart of the March 14, 1998 visit, Respondent added the complaint of "depression". He also added "front occipital" to further describe the left sided headaches. On the original of Respondent's chart of the April 22, 1998 visit, Respondent added a past history of "depression, panic attacks and paranoia." The respiratory rate was

[8] The experts disagreed on this, and many other issues. As noted above, these Findings are based on an analysis of the testimony coupled with extensive review of the records. A recitation of the testimony for each Finding is not needed. The following example (other abound in the record) should suffice: On December 1, 1997, Respondent noted a diagnosis of acute pneumonitis, but there was nothing to indicate that the child had pneumonia or any localized infection in the pulmonary fields to justify postural drainage. The child's respiratory rate of 15 was normal and indicated that the child had no respiratory distress whatsoever. There also was insufficient information regarding a perforation of the patient's eardrum to justify an ENT referral. Respondent's contention that his poor record keeping should not be taken as a measure of his medical competence was not supported by the evidence and is rejected.

whited out and changed from 15 on the insurance copy to 17 on the original record. On Respondent's original chart of the December 29, 1998 visit, the box over neurological was marked "no", indicating that originally there were no neurologic episodes, then whited out and marked "yes". With regard to past history, "marital problems" was added, and under neurological, "nervous, shaky and marital problems" was added. On the original of the the chart for January 11, 1999, the respiratory rate was whited out. Under "other relevant data", Respondent added "past history of of marital problems and depression, and that the patient was receiving psychiatric therapy. There is also an addition of "hypograstic discomfort" under abdominal examination. "Vitamins" and "encourage fluids" were added under "plan".

13. Respondent administered injections of antibiotics to L.M. without documented medical rationale or justification. On September 15, 1997, the patient was given an injection of Ancef which was not medically indicated. On December 29, 1998 and January 11, 1999, the patient was given an injection of Ampicillin for which there was no justification.

14. Respondent repeatedly ordered and/or performed diagnostic testing without documented medical rationale or justification and failed to properly treat those things he did diagnose. On February 11, 1998, the patient was diagnosed with acute lumbosacral sprain. Physical therapy was performed once only, instead of an extended course of treatment. On March 6, 1998, the patient was again diagnosed with lumbosacral sprain, although there is no history of trauma, and she was again given another one time physical therapy treatment. Respondent repeated urinalyses and urine cultures, many of which were positive, but then failed to address why they were repetitively positive. Respondent continually used ultrasounds for the patient's abdominal pain but never took an adequate history to help him diagnose, and therefor be able to treat, the abdominal pain. The character of the pain, such as locations, durations, onsets, and what triggered the pain were not mentioned. On April 22, 1998, the patient indicted that she was depressed, having panic attacks, and was paranoid. The record does not indicate that Respondent addressed these behaviors at all.

15. As of March 6, 1998, L.M. had been diagnosed at least three or four times with peptic ulcer disease and she had a history of having tested positive for H. pylori. However, Respondent failed to evaluate her upper abdomen through an upper G.I. series or by endoscopy. On April 22, 1998, the patient was again diagnosed with peptic ulcer disease with no appropriate testing. Respondent's diagnosis of gallstones on this date is unsupported by any kind of medical evidence and is contraindicated by two negative ultrasounds. By the October 10, 1998 visit, Respondent should have, but again failed, to refer L.M. to a urologist, or order more advanced testing, even though by this time she had four or five recurrent bladder infections.

16. On December 10, 1998, Respondent misdiagnosed L.M. as having a stroke when she was actually having a panic attack. As a result, she underwent unnecessary hospitalization for three days. A CAT scan was performed which was negative, and an MRI was performed which was normal. On December 29, 1998, the patient was again diagnosed with acute cystitis. This was the seventh infection the patient had had in the last fifteen months. Respondent still failed to properly evaluate the patient for this persistent problem.

On this date the patient still had persistent complaints or peptic ulcer disease, and Respondent again failed to evaluate this problem as well.

## PATIENT C.C.

17. Patient C.C., a 46 year old female, had her first office visit with Respondent on March 9, 1998. On that initial visit, the patient complained of hot flashes, irritability, neck pain, and being tired or weak. Respondent's diagnoses of the patient included menopausal syndrome, acute cervical strain, and "body weakness". The medical record indicates the patient "denies direct trauma to neck" yet she was treated with two intramuscular injections. Over the next 11 months, C.C. had thirty-two visits to Respondent's office. She was treated for a variety of complaints including various strains (cervical, back strains and others), "body weakness", and minor infections. She was treated with physical therapy, trigger point injections, at least 10 injectable and oral antibiotics and multiple other medications. She was evaluated with a variety of diagnostic testing including MRI scans of the hip, back and neck and ultrasounds of the pelvis and abdomen. Abdominal ultrasounds were performed twice, on May 28, 1998 and again on January 28, 1999.

18. As with the records of the last two patients, Respondent repeatedly altered or modified, without explanation, the medical records C.C. in areas such as examination, findings and treatment plans. On the certified copy of Respondent's chart of the March 21, 1998 visit, "wants a steroid shot in L elbow, difficulty using left elbow, irritable, poor appetite", and a check mark indicating symptoms unrelieved were added after that record was sent to the insurance company, but before the records were turned over to the Board. On the chart for the April 6, 1998 visit, a past history of "hyperlipidemia" and "elevated cholesterol panel" were added. Under "diagnosis" on the chart, there was white out and "body weakness" was added. Also written in another ink was "two weeks if unrelieved." The comment that the patient refused neck and shoulder x-rays and "return to clinic in one to two weeks" was added as well. There also were relatively minor alterations or modifications to respondent's chart of the office visits of May 13, 1998; May 28, 1998; June 6, 1998; June 10, 1998; June 22, 1998; June 27, 1998; July 8, 1998; July 24, 1998, August 5, 1998, August 8, 1998; September 8, 1998, September 30, 1998, October 5, 1998, October 21, 1998, October 26, 1998; November 2, 1998; November 4, 1998 and November 9, 1998. None of the alterations was initialed or dated.

19. Respondent routinely administered injections of antibiotics and hormones to the patient, allegedly upon her request, but without documented medical rationale or justification. On June 22, 1998, Respondent provided the patient with an injection of Ancef, a course of Amoxicillin and postural drainage, none of which was medically indicated. The patient also was given an injection of Ancef that was not medically indicated on June 27, 1998 as well as August 5, 1998, and continued treatment with hormones without justification. On numerous visits thereafter, Respondent continued to prescribe and administer antibiotics and estrogen without medical justification.

20. Respondent repeatedly ordered and/or performed diagnostic testing or treatment on C.C. without documented medical rationale or justification. On the March 9, 1998 visit, Respondent administered a B-12 shot and provided one-time physical therapy neither of which were medically indicated. On the March 21, 1998 visit, Respondent provided physical therapy and an injection of Nubain, which is for treatment of acute severe pain, neither of which were medically indicated. On April 27, 1998 visit, Respondent made a diagnosis of acute cervical sprain without documented rationale. On May 28, 1998, there was no justification for ordering a complete blood test when one was done about six weeks prior thereto. On June 6, 1998, Respondent made a diagnosis of a herniated disc when there was no documented indication of that condition. The orders for physical therapy and for MRI's of the back and hip were likewise baseless. On the June 10, 1998 visit, Respondent's diagnosis of "acute labyrinthitis" was unfounded, and his prescription of Antivert not justified. Respondent's repetition of a syphilis test, thyroid studies and arthritis panel were unnecessary and not justified, especially after recent tests results were negative. On June 27, 1998, Respondent diagnosed the patient to have peptic ulcer disease without supporting such diagnosis in his chart. On October 5, 1998, Respondent prescribed and administered Nubain and a repeat testing for H. pylori that were not medically indicated. On October 21, 1998, Respondent ordered a postural drainage that was not medically indicated.

**PATIENT S.R.**

21. Patient S.R., a 34 year old male, had his first office visit with Respondent on July 25, 1998. On that initial visit, the patient complained of being tired and weak and having a cough. S.R. had a history of anemia. Respondent's physical examination of the patient was significant only for the presence of mucous rales in the lung fields. Respondent's diagnoses of the patient included "body weakness, anemia, acute bronchitis, and acute pneumonitis." The diagnostic studies included spirometry, comprehensive blood test, urinalysis, and chest X-ray. The patient was treated with Phenergan DM for cough and oral Amoxil, an antibiotic. The diagnostic tests were significant for elevation of liver enzymes. In addition, his LDL cholesterol was modestly elevated. The spirometry results were normal. Results of the X-ray were not documented.

22. Over the next 16 months, S.R. visited Respondent's office 22 times. Respondent's treatment of S.R. was deficient in the following respects: Respondent failed to document results of the chest X-ray ordered on July 25, 1998. He failed to order serologic testing for viral hepatitis on July 25, 1998 or October 7, 1998, when liver tests indicated he should. He diagnosed H. pylori gastritis on November 2, 1998, despite a negative test for the presence of H. pylori. He then prescribed Biaxin, presumably to treat H. pylori; however, in order to successfully treat H. pylori at least two synergistic antibiotics must be used. The injections of Ancef on December 4, 1998 and March 15, April 7, April 14, April 19, August 10, September 17 and December 3, 1999 were all unnecessary. His evaluation of the patient was inadequate to make a diagnosis of cystitis; but in light of that diagnosis, he should have obtained a sexual history. He failed to perform or document genital and prostate examinations on April 7 and on September 17, 1999, when these examinations were

indicated. He failed to address the positive Giardia study on May 20, 1999. He failed to evaluate the etiology of the patient's recurrent urinary symptoms.

23. No adverse Findings are made regarding changes Respondent may have made on this patient's chart between the time he sent his records to the insurance company and the time he sent them to the Board, as only one page of the chart (the August 10, 1999 visit) which had been sent to the insurance company was offered in evidence. However, a review of the original chart shows Respondent made numerous "corrections" by white-out and write-over. These changes are found on the chart pages for office visits on November 21, 1998, November 23, 1998, March 3, 1999, March 15, 1999, March 24, 1999 and December 3, 1999. It could not be determined what, if anything, had been changed, except with respect to the December 3, 1999 chart note. There, the temperature was changed from 98.9 to 100.1. In addition, items 2 and 3 (out of 11) of the plan were whited-out, written over and changed, although the exact nature of the change could not be determined. None of the changes were initialed or dated.

24. It is true the chart copies sent to the Board had, in many cases, more and different information on them than those sent to the insurance company. However, in many of the cases, the "extra information" was actually available and already in the patients' charts from prior visits, or simply more specifically described an already noted event. Respondent admittedly added the data. However, he did not make these changes to defraud the insurance company into paying false claims, as the insurance company received the records before any additions or corrections had been made. There is nothing inherently illegal, immoral, unethical or violative of the Medical Practice Act in a physician adding information to a patient's chart to make it complete and accurate. In fact, this practice should be encouraged. The rationale for Respondent to make the additions was to make his records appear more complete and thus look better on review by the Board. Testimony showed that in some instances, the additions did in fact better describe what had already been charted. However, there were also times where the changes were made for no discernable reason and with no factual basis. These changes were generally of a minor nature and did nothing to make it appear that Respondent's treatment of a patient on any given day was medically appropriate.

25. By Order effective December 8, 1994, the Board issued Respondent a public reprimand, which is deemed to be license discipline. The reprimand was based on Respondent's 1987 Louisiana conviction for Medicaid fraud. Respondent's Louisiana medical license was revoked in 1991 based on that conviction. Thereafter, Respondent's Ohio medical license was also revoked. The Board's discipline was mild due in large part to Findings that at that time the conviction was over eight years old, there had been no other reported criminal conduct, Respondent had performed hundreds of hours of voluntary community service, the amount involved was less than $300, and Respondent had been licensed in California for 15 years with no prior disciplinary history.

26. Respondent now has been licensed in California for more than 23 years and has actively practiced here for more than 10 years. He has no prior disciplinary history, other than as noted above. The Board has not accused him of causing actual patient harm,

although patient harm is not a prerequisite for imposition of discipline. None of the patients discussed above filed any complaint with the Board. This matter was brought to the Board's attention, and properly so, by an insurance company. Respondent runs two offices and serves a large low-income population. He possesses the basic skills needed to properly treat his patients. However, he is sorely in need of additional training and monitoring, as well as intensive instruction in record keeping. Respondent can practice medicine safely, but only if his medical license is conditioned with the restrictions set forth in the below Order.

27. The Board has incurred costs, including fees of the Attorney General, in connection with the investigation and prosecution of this matter. Costs of the expert witness totaled $1300. Recoverable costs of the Attorney General total $17,918.[9] The amount of recoverable investigative costs, if any, could not be determined from the evidence presented.[10]

* * * * *

## CONCLUSIONS OF LAW

1. Respondent's care and treatment of patients S.M., L.M., C.C. and S.R. fell below the standard of care on numerous instances, as set forth Findings 10, 13, 14, 15, 16, 19, 20 and 22. Respondent has thus committed repeated negligent acts within the meaning of Business and Professions Code Section 2234(c).

2. Respondent's alteration of his medical records, as set forth in Findings 8, 9, 12 and 18, constitutes the making of false representations in a document related to the practice of medicine, within the meaning of Business and Professions Code Section 2261.

3. Respondent failed to maintain adequate and accurate medical records, within the meaning of Business and Professions Code Section 2266, by reason of Findings 10, 13, 14, 15, 19 and 20.

4. The Board is entitled to recover from Respondent its reasonable costs of investigation and prosecution of this matter in the total amount of $19,218 under the provisions of Business and Professions Code Section 125.3, by reason of Finding 27.

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[9] This is the amount actually incurred up to the time of trial. The fees for the services of Ms. Tan were incurred after trial commenced, and are not recoverable under Business and Professions Code Section 125.3. In any event, Ms. Tan's fees were incurred, in large part, in familiarizing herself with the file after the lengthy break in the trial. The delay was not the fault of the Respondent and it would be inequitable to require him to pay fees based on that delay.

[10] The investigator fees were based on a composite hourly rate pursuant to the State Administrative Manual. Thus the fees, the hourly rate of which rivaled those of the Attorney General, were "grossed up" to include overhead items such as rent, utilities and the like. The investigators were Board employees, and these "grossed up" costs were not the result of the investigation of this particular matter. No evidence was offered to show what investigative costs, if any, were actually incurred by the Board as a direct result of its use of its own employees.

* * * * *

ORDER

WHEREFORE, THE FOLLOWING ORDER is hereby made:

Certificate No. A34298 issued to respondent Antonio A. Romero is revoked; provided however, that the revocation is stayed and respondent is placed on probation for seven (7) years upon the following terms and conditions:

**1. Actual Suspension**

As part of probation, respondent is suspended from the practice of medicine for 60 days beginning the sixteenth (16th) day after the effective date of this decision.

**2. Education Course**

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the Division or its designee for its prior approval educational programs or courses that shall not be less than 40 hours per year, for each year of probation. The educational programs or courses shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified, limited to classroom, conference, or seminar settings. The educational programs or courses shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Division or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

**3. Medical Record Keeping Course**

Within 60 calendar days of the effective date of this decision, respondent shall enroll in a course in medical record keeping, at respondent's expense, approved in advance by the Division or its designee. Failure to successfully complete the course during the first 6 months of probation is a violation of probation.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the

Division or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Division or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Division or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

**4. Ethics Course**

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in ethics, at respondent's expense, approved in advance by the Division or its designee. Failure to successfully complete the course during the first year of probation is a violation of probation.

An ethics course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Division or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Division or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Division or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

**5. Clinical Training Program**

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of California - San Diego School of Medicine ("Program").

The Program shall consist of a Comprehensive Assessment program comprised of a two-day assessment of respondent's physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment pertaining to respondent's specialty or sub-specialty, and at minimum, a 40 hour program of clinical education in the area of practice in which respondent was alleged to be deficient and which takes into account data obtained from the assessment, Decision, Accusation, and any other information that the Division or its designee deems relevant. Respondent shall pay all expenses associated with the clinical training program.

Based on respondent's performance and test results in the assessment and clinical education, the Program will advise the Division or its designee of its recommendation(s) for the scope

and length of any additional educational or clinical training, treatment for any medical condition, treatment for any psychological condition, or anything else affecting respondent's practice of medicine. Respondent shall comply with Program recommendations.

At the completion of any additional educational or clinical training, respondent shall submit to and pass an examination. The Program's determination whether or not respondent passed the examination or successfully completed the Program shall be binding.

Respondent shall complete the Program not later than six months after respondent's initial enrollment unless the Division or its designee agrees in writing to a later time for completion.

Failure to participate in and complete successfully all phases of the clinical training program outlined above is a violation of probation.

Respondent shall not practice medicine until respondent has successfully completed the Program and has been so notified by the Division or its designee in writing, except that respondent may practice in a clinical training program approved by the Division or its designee. Respondent's practice of medicine shall be restricted only to that which is required by the approved training program.

After respondent has successfully completed the clinical training program, respondent shall participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, which shall include quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation, or until the Division or its designee determines that further participation is no longer necessary.

Failure to participate in and complete successfully the professional enhancement program outlined above is a violation of probation.

**6. Oral and/or Written Examination**

Within 60 calendar days of the effective date of this Decision, respondent shall take and pass an oral and/or written examination, administered by the Probation Unit. The Division or its designee shall administer the oral and/or written examination in a subject to be designated by the Division or its designee and the oral examination shall be audio tape recorded.

If respondent fails the first examination, respondent shall be allowed to take and pass a second examination, which may consist of an oral and/or written examination. The waiting period between the first and second examinations shall be at least 90 calendar days.

Failure to pass the required oral and/or written examination within 180 calendar days after the effective date of this Decision is a violation of probation. Respondent shall pay the costs of all examinations. For purposes of this condition, if respondent is required to take and pass a written exam, it shall be either the Special Purpose Examination (SPEX) or an equivalent examination as determined by the Division or its designee.

Respondent shall not practice medicine until respondent has passed the required examination and has been so notified by the Division or its designee in writing. This prohibition shall not bar respondent from practicing in a clinical training program approved by the Division or its designee. Respondent's practice of medicine shall be restricted only to that which is required by the approved training program.

**7. Monitoring**

Within 15 calendar days of resumption of practice, respondent shall submit to the Division or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Division, including but not limited to any form of bartering, shall be in respondent's field of practice, and must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

The Division or its designee shall provide the approved monitor with copies of the Decision and Accusation, and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision, Accusation, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision and Accusation, fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement.

Continuing throughout probation, respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

The monitor shall submit a quarterly written report to the Division or its designee which includes an evaluation of respondent's performance, indicating whether respondent's practices are within the standards of practice of medicine, and whether respondent is practicing medicine safely.

It shall be the sole responsibility of respondent to ensure that the monitor submits the quarterly written reports to the Division or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Division or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 days of the resignation or unavailability of the monitor, respondent shall be suspended from the practice of medicine until a replacement monitor is approved and prepared to assume immediate monitoring responsibility. Respondent shall cease the practice of medicine within 3 calendar days after being so notified by the Division or designee.

Failure to maintain all records, or to make all appropriate records available for immediate inspection and copying on the premises, or to comply with this condition as outlined above is a violation of probation.

**8. Notification**

Prior to engaging in the practice of medicine the respondent shall provide a true copy of the Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Division or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

**9. Supervision of Physician Assistants**

During probation, respondent is prohibited from supervising physician assistants.

**10. Obey All Laws**

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

## 11. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

## 12. Probation Unit Compliance

Respondent shall comply with the Division's probation unit. Respondent shall, at all times, keep the Division informed of respondent's business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Division or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Respondent shall not engage in the practice of medicine in respondent's place of residence.

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Respondent shall immediately inform the Division or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

## 13. Interview with the Division or it's Designee

Respondent shall be available in person for interviews either at respondent's place of business or at the probation unit office, with the Division or its designee upon request at various intervals and either with or without prior notice throughout the term of probation.

## 14. Residing or Practicing Out-of-State

In the event respondent should leave the State of California to reside or to practice respondent shall notify the Division or its designee in writing 30 calendar days prior to the dates of departure and return. Non-practice is defined as any period of time exceeding thirty calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program outside the State of California which has been approved by the Division or its designee shall be considered as time spent in the practice of medicine within the State. A Board-ordered suspension of practice shall not be considered as

a period of non-practice. Periods of temporary or permanent residence or practice outside California will not apply to the reduction of the probationary term. Periods of temporary or permanent residence or practice outside California will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; Probation Unit Compliance; and Cost Recovery.

Respondent's license shall be automatically cancelled if respondent's periods of temporary or permanent residence or practice outside California totals two years. However, respondent's license shall not be cancelled as long as respondent is residing and practicing medicine in another state of the United States and is on active probation with the medical licensing authority of that state, in which case the two year period shall begin on the date probation is completed or terminated in that state.

## 15. Failure to Practice Medicine - California Resident

In the event respondent resides in the State of California and for any reason respondent stops practicing medicine in California, respondent shall notify the Division or its designee in writing within 30 calendar days prior to the dates of non-practice and return to practice. Any period of non- practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding thirty calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program which has been approved by the Division or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a Board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.

Respondent's license shall be automatically cancelled if respondent resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code sections 2051 and 2052.

## 16. Completion of Probation

Respondent shall comply with all financial obligations (e.g., cost recovery, restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon completion successful of probation, respondent's certificate shall be fully restored.

## 17. Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Division, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

## 18. Cost Recovery

Within 90 calendar days from the effective date of the Decision or other period agreed to by the Division or its designee, respondent shall reimburse the Division the amount of $19,218 for its investigative and prosecution costs. The filing of bankruptcy or period of non-practice by respondent shall not relieve the respondent his/her obligation to reimburse the Division for its costs.

## 19. License Surrender

Following the effective date of this Decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request the voluntary surrender of respondent's license. The Division reserves the right to evaluate respondent's request and to exercise its discretion whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Division or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation and the surrender of respondent's license shall be deemed disciplinary action.

If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

## 20. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Division, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Division or its designee no later than January 31 of each calendar year. Failure to pay costs within 30 calendar days of the due date is a violation of probation.

Date: January 14, 2004

RALPH B. DASH
Administrative Law Judge
Office of Administrative Hearings

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Attorneys for Complainant



**BEFORE THE**
**DIVISION OF MEDICAL QUALITY**
**MEDICAL BOARD OF CALIFORNIA**
**DEPARTMENT OF CONSUMER AFFAIRS**
**STATE OF CALIFORNIA**

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| In the Matter of the Accusation Against:<br><br>**ANTONIO A. ROMERO, M.D.**<br>9321 Florence Avenue<br>Downey, California 90240<br><br>Physician and Surgeon's Certificate No. A34298<br><br>Respondent | Case No. 11-1999-97648<br><br>**FIRST AMENDED ACCUSATION** |

Complainant alleges:

## PARTIES

1. Ron Joseph ("Complainant") brings this first amended accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs.

2. On or about August 13, 1979, the Medical Board of California issued Physician and Surgeon's Certificate Number A34298 to Antonio A. Romero, M.D. ("Respondent"). The Physician and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2003, unless renewed.

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## JURISDICTION

3. This Accusation is brought before the Division of Medical Quality, Medical Board of California ("Division"), under the authority of the following sections of the Business and Professions Code ("Code").

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Division deems proper.

5. Section 2234 of the Code provides that unprofessional conduct includes, but is not limited to, the following:

(a) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter.

(b) Gross negligence.

(c) Repeated negligent acts.

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct which would have warranted the denial of a certificate.

6. Section 725 of the Code provides that repeated acts of clearly excessive prescribing or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct.

7. Section 2261 of the Code provides that knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct.

8. Section 2262 of the Code provides that altering or modifying the medical record of any person, with fraudulent intent, or creating any false medical record, with fraudulent intent, constitutes unprofessional conduct.

9. Section 2266 of the Code provides that the failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

10. Section 125.3 of the Business and Professions Code states, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

11. Section 14124.12 of the Welfare and Institutions Code states:

(a) Upon receipt of written notice from the Medical Board of California, the Osteopathic Medical Board of California, or the Board of Dental Examiners of California, that a licensee's license has been placed on probation as a result of a disciplinary action, the department may not reimburse any Medi-Cal claim for the type of surgical service or invasive procedure that gave rise to the probation, including any dental surgery or invasive procedure, that was performed by the licensee on or after the effective date of probation and until the termination of all probationary terms and conditions or until the probationary period has ended, whichever occurs first. This section shall apply except in any case in which the relevant licensing board determines that compelling circumstances warrant the continued reimbursement during the probationary period of any Medi-Cal claim. including any claim for dental services, as so described. In such a case, the department shall continue to reimburse the licensee for all procedures, except for those invasive or surgical procedures for which the licensee was placed on probation.

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**FIRST CAUSE FOR DISCIPLINE**

(Gross Negligence)

12. Respondent is subject to disciplinary action under section 2234, subdivision (b), in that he has committed acts of gross negligence in his care and treatment of patients. The circumstances are as follows:

Patient S.M.

A. On or about September 26, 1997, patient S.M., a 2 year old male, was brought to respondent's office for treatment. According to the medical record for this visit, the chief complaints were nausea, vomiting, loose bowel movements, and a cough. Respondent's diagnosis included acute pharyngitis, acute bronchitis, and acute gastroenteritis. Several diagnostic tests, including throat and stool cultures, were performed, and medicine was prescribed.

B. Another visit occurred on or about November 12, 1997. According to the medical record for this visit, the chief complaints were runny nose, and a notation that the patient was "tired/weak." Respondent's diagnosis included anemia and acute rhinitis, although no tests or examination are noted to confirm such diagnoses.

C. Another visit occurred on or about December 1, 1997. According to the medical record for this visit, the chief complaints were right ear discharge, running nose, sore throat and coughing. Respondent's diagnosis included acute otitis media (right) with tympanic membrane perforation, acute rhinitis, acute bronchitis, and acute pneumonitis. Several diagnostic tests, including throat and ear cultures, were performed, an intramuscular injection of Ampicillin was administered, antibiotics were prescribed, and an ENT referral was recommended.

D. Another visit occurred on or about February 11, 1998. According to the medical record for this visit, the chief complaints were poor appetite, allergies, running nose, and another notation that the patient was "tired/weak." Respondent's diagnosis included "body weakness," inhalant allergy, acute allergic rhinitis, and acute otitis media, although there is no documentation in the record of an otic examination.

Treatment included another intramuscular injection of Ampicillin (at "mother's request"), and another referral, this time to a pediatric pulmonary or allergy specialist, was recommended.

E. Another visit occurred on or about February 25, 1998. According to the medical record for this visit, the chief complaints were runny nose, sore throat, and coughing. Respondent's diagnosis included acute rhinitis, acute tonsilitis, acute bronchitis, and acute pneumonitis. Treatment again included another intramuscular injection of Ampicillin, and again another referral was recommended, this time to an allergy specialist or pediatrician. A chest x-ray ordered at this visit showed a mild interstitial process which according to the radiologist "could be due" to bronchitis, but "without consolidation or effusion."

F. Another visit occurred on or about April 10, 1998. According to the medical record for this visit, the chief complaints were a rash and allergies. Respondent's diagnosis included "impetigo" and allergic dermatitis for the rash, along with acute bronchitis, although there is no indication in the record of any examination in support of this. Yet again, respondent administered an intramuscular injection of Ampicillin. Of note regarding this visit is the fact that the record sent to the insurance company for reimbursement differs from the record which was provided to the Board during investigation, specifically in the "accompanying symptoms" of the chief complaints and the findings of an abdominal exam, neither of which were noted in the insurance copy.

G. Another visit occurred on or about April 22, 1998. According to the medical record for this visit, the chief complaints were coughing, night fever, and abdominal pains. Respondent's diagnosis included acute bronchitis, acute pneumonitis, and "possible" tuberculosis. Yet again, respondent administered an intramuscular injection of Ampicillin. The record sent to the insurance company differs substantially from the record which was provided to the Board during investigation, specifically in that

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the entire "RX & Plan" and "accompanying symptoms" sections have been rewritten, as well as several vital signs and HEENT notes.

Between December 28, 1998 and February 1, 1999, there were six (6) more documented visits where oral antibiotics were prescribed on each occasion. On four out of the six visits, injectable antibiotics were administered.

H. Another visit occurred on or about January 11, 1999. According to the medical record for this visit, the chief complaints were cough, runny nose, and chest congestion. Respondent's diagnosis included acute allergic rhinitis, acute bronchitis, inhalant allergy, and tuberculosis. Yet again, respondent administered an intramuscular injection of Ampicillin. Yet again, the record sent to the insurance company differs substantially from the record which was provided to the Board during investigation, specifically in that the entire document seems to have been rewritten, with completely different treatment plans and examination findings.

I. Another visit occurred on or about February 1, 1999. According to the medical record for this visit, the chief complaints were sore throat, coughing, and chest congestion, although the record provided to the Board also indicates allergies, as well as other differences in examination findings. Respondent's diagnosis according to both records includes acute tonsilitis, acute bronchitis, acute pneumonitis, and inhalant allergy. Yet again, respondent administered an intramuscular injection of Ampicillin.

J. Respondent has subjected his license to discipline, in that considered singularly as well as collectively:

i) On at least four (4) occasions, he altered or otherwise modified without explanation the medical records of patient S.M. in areas such as examination findings, vital signs, and treatment plans; and

ii) He routinely administered injections of Ampicillin to patient S.M. without documented medical rationale or justification.

iii) He failed to maintain adequate records for patient S.M.'s care and treatment.

Patient L.M.

K. On or about September 2, 1997, patient L.M., a 27 year old female, presented to respondent's office, complaining of depression, weakness, and a fungal infection of both feet. Respondent's diagnosis included depression, "body weakness," tinea ungium, and bacteruria. She was given a full panel of diagnostic studies, and was prescribed oral antibiotics and a different anti-depressant. Respondent billed the insurance company $340 for this visit.

L. Another visit occurred on or about September 24, 1997. According to the medical record for that visit, the chief complaints were heartburn, "gassiness," pelvic pain, and irregular vaginal bleeding. Between the date of this appointment and September 27, 1997, the patient was seen by either respondent or his wife (who is also a licensed physician) five (5) times. Pelvic and abdominal ultrasounds were performed, and several other tests and studies were ordered, including a pap, artery scan, EKG, and urinalysis. All results were within normal limits. Respondent and/or his wife billed the insurance company approximately $1700 for this series of visits.

M. Between December 29, 1997, and February 1, 1999, respondent saw this patient on approximately nine (9) other occasions. During these visits, he administered approximately six (6) intramuscular injections of antibiotics, and ordered multiple tests and studies for her, billing the insurance company approximately $3400 for these visits.

N. At the visit occurring on or about December 29, 1998, the patient presented complaining of left side numbness, "weakness of whole body," and "bone & body pain." Respondent's diagnosis included "body weakness" and "cerebrovascular accident." Despite no relevant neurological history, respondent admitted the patient into a hospital for further evaluation, citing a "strong possibility of an impending" CVA. The patient was hospitalized for four days; CT scans and MRI scans were performed, all of which were normal, and neurological and psychiatric consultations were obtained, which indicated that the numbness was psychosomatic.

O. Respondent's records for the visits of March 14, 1998; April 22, 1998; October 10, 1998; December 29, 1998; and January 11, 1999, as provided to the insurance company, differ substantially from respondent's records for those visits as provided to the Board during investigation, primarily in the areas of examination findings and treatment plan (which for October 10, 1998, appears to have been rewritten entirely).

P. Respondent has subjected his license to discipline in that considered singularly as well as collectively:

i) On at least five (5) occasions, he altered or otherwise modified without explanation the medical records of patient L.M. in areas such as examination findings and treatment plans;

ii) He routinely administered injections of antibiotics to patient L.M. without documented medical rationale or justification; and

iii) He routinely ordered and/or performed diagnostic testing on this patient without documented medical rationale or justification.

Patient C.C.

Q. On or about March 9, 1998, patient C.C., a 46 year old female, presented to respondent's office, complaining of hot flashes, irritability, neck pain, and weakness. Respondent's diagnosis included menopausal syndrome, acute cervical strain, and "body weakness." The medical record for this visit indicates the patient "denies direct trauma to neck." Treatment included two intramuscular injections. Respondent billed the insurance company $470 for this visit.

R. The patient returned on or about March 21, 1998, complaining of elbow and shoulder pain. Again, the record indicates the patient denies direct trauma to the areas of the body in which she is experiencing pain. Treatment included two intramuscular injections. Of note regarding this visit is the fact that the record sent to the insurance company for reimbursement differs from the record which was provided to the Board during investigation, specifically in the "accompanying symptoms" of the chief complaints and the findings of an abdominal exam, neither of which were noted in the

insurance copy, and in a notation in the "chief complaint" section that the patient "wants a steroid shot for [left] elbow." Respondent billed the insurance company $360 for this visit.

S. The patient returned on or about April 6, 1998, complaining of neck pain, left shoulder pain, and "body weakness." Treatment included two intramuscular injections., Again, the record provided to the Board differs from that provided to the insurance company, specifically in that the treatment plan has been altered to include a recommendation to undergo cervical spine and shoulder x-rays, and in that "body weakness" has been added to the diagnosis of acute cervical sprain, acute left deltoid bursitis, and hyperlipidemia. Respondent billed the insurance company $370 for this visit.

T. Another visit occurred on or about May 28, 1998. The patient was again complaining of pain, as well as sinus drainage. Respondent's diagnosis includes "body weakness." Again, the record provided to the Board differs from that provided to the insurance company, specifically in that the treatment plan has been altered to include an intramuscular injection of Benadryl "for allergy to dust/pollen," and the chief complaint now includes a patient request for blood tests. Several blood tests were ordered this visit, none of which were abnormal. Respondent billed the insurance company $320 for this visit.

U. Another visit occurred on or about June 10, 1998. The chief complaints listed in the record include headaches, dizziness, chest discomfort, and "body weakness." Respondent ordered both an EKG, which was normal, and an MRI of both the hips, which was normal, and the lumbosacral spine, which was normal.

V. Another visit occurred on or about June 22, 1998. Again, the record provided to the Board differs from that provided to the insurance company, in that nausea has been added to the chief complaints, and in that the abdominal exam findings have been rewritten. Treatment included an intramuscular injection of an antibiotic, Ancef. Respondent billed the insurance company $250 for this visit.

W. Another visit occurred on or about June 27, 1998. Again, the record provided to the Board differs from that provided to the insurance company, in that notes have been added to the accompanying symptoms and abdominal exam findings. Treatment included another intramuscular injection of Ancef. Respondent billed the insurance company $290 for this visit.

X. Another visit occurred on or about August 5, 1998. Again, the record provided to the Board differs from that provided to the insurance company, most notably in that "requests hormone shots" has been added to the chief complaints. Respondent's diagnosis includes "body weakness." Treatment included intramuscular injections, including another of Ancef, and multiple blood tests, all of which were normal. Respondent billed the insurance company $350 for this visit.

Y. Another visit occurred on or about August 18, 1998. Again, the record provided to the Board differs from that provided to the insurance company, most notably in that "wants blood tested" has been added to the chief complaints. Respondent's diagnosis includes "body weakness." Treatment included another intramuscular injection of Ancef, and multiple blood tests; the only abnormality indicates the patient was low in iron. Respondent billed the insurance company $290 for this visit.

Z. Another visit occurred on or about September 8, 1998. Again, the record provided to the Board differs from that provided to the insurance company, most notably in that "requests hormone shot" has been added to the chief complaints. Respondent's diagnosis includes "body weakness." Respondent billed the insurance company $290 for this visit.

AA. Another visit occurred on or about October 26, 1998. Again, the record provided to the Board differs from that provided to the insurance company, most notably in that "requests antibiotic shot" has been added to the chief complaints. Treatment included another intramuscular injection of Ancef, as well as a thyroid ultrasound, which was normal. Respondent billed the insurance company $630 for this visit.

BB. Another visit occurred on or about November 16, 1998. Again, the record provided to the Board differs from that provided to the insurance company, in that the accompanying symptoms, diagnosis, and treatment plan have all been rewritten. Treatment included another intramuscular injection of Ancef. Respondent billed the insurance company $210 for this visit.

CC. Another visit occurred on or about January 28, 1999. Again, the record provided to the Board differs from that provided to the insurance company, in that notes have been added to the chief complaints and treatment plan. Treatment included an abdominal ultrasound, which was normal. Respondent billed the insurance company $690 for this visit.

DD. Between March 9, 1998, and January 28, 1999, respondent saw this patient on approximately thirty-two (32) occasions. During these visits, he administered approximately fourteen (14) intramuscular injections of antibiotics, ordered multiple tests and studies, and billed the insurance company approximately $9940 for these visits. On approximately eleven (11) occasions, as set forth above, respondent's records as provided to the insurance company, differ substantially from respondent's records for those visits as provided to the Board during investigation.

EE. Respondent has subjected his license to discipline in that considered singularly as well as collectively:

i) On at least eleven (11) occasions, he altered or otherwise modified without explanation the medical records of patient C.C.;

ii) He routinely administered injections of antibiotics and hormones to patient C.C. allegedly upon her request, without documented medical rationale or justification; and

iii) He routinely ordered and/or performed diagnostic testing on this patient without documented medical rationale or justification.

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Patient S.R.

GG. On or about July 25, 1998, patient S.R., a 34 year old male, presented to respondent's office for treatment. According to the medical record for (a template type medical chart[1]) this visit, the patient complained of being tired and weak, and a cough. Physical examination was remarkable only for the presence of mucous rales in the lung fields. Respondent's diagnosis included body weakness, anemia, acute pneumonitis, acute bronchitis, and acute gastroenteritis. Diagnostic tests ordered included, spirometry, comprehensive blood tests, urinalysis, and chest x-ray. The patient was treated with phenergan DM for cough and given an oral antibiotic (Amoxil). The patient was also advised to take Centrum Silver vitamins. However, despite a history of weakness and anemia, no blood count was ordered.

HH. On or about July 27, 1998, the results of the diagnostic tests were significant for an elevation of liver enzymes. No chest x-ray results were documented in the medical records.

II. On October 7, 1998, the patient returned with complaints of upper abdominal pain and indigestion. The patient also presented for a follow-up on the abnormal liver function tests. Again, mucous rales was noted. The medical template showed epigastric tenderness. Respondent's diagnosis included Anicteric Hepatitis, Hepatomegaly, and Gallstones. An abdominal ultrasound was ordered and the patient was instructed to avoid alcohol. The ultrasound report showed a contracted gallbladder without observed gallstones. No hepatitis screen was ordered, however, to screen for the presence of viral hepatitis.

JJ. On October 8, 1998, the patient returned complaining of persistent cough. Respondent diagnosed the patient with acute bronchitis, acute pneumonitis, hyperlipidemia, and an inhalant allergy. A spirometry was ordered again and the results

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1. Respondent consistently utilized a template type of notation system for medical record keeping in his practice.

returned normal. The patient was treated with Amoxil and Phenergan DM. The patient was also advised to stop smoking and to follow a low fat diet.

KK. On November 2, 1998, the patient again returned to respondent's office. The medical template recorded the patient complained of a runny nose and chest tightness. The patient also had persistent complaints of heartburn. Respondent diagnosed acute bronchitis, inhalant allergy and peptic ulcer disease. An upper endoscopy was scheduled which was performed by respondent. Findings included Gastroesophageal Reflux Disease (GERD), esophagitis, gastroduodenitis and H.pyloria gastritis. Pathology reports confirmed the chronic duodenitis. However, the gastric and esophageal biopsies were normal. The H.Pylori test was negative.

LL. On November 21, 1998, the patient returned for a follow up for heartburn and gassiness. Despite the negative H.pylori test, respondent made a diagnosis of helicobacter phylor gastritis and treated the patient with a course of Prilosec and Biaxin (an antibiotic used against H pylori). Respondent reports that the antibody IgG test was positive. However, this is not documented anywhere in the medical record and it also contradicts the report from Bellflower Medical Center Clinical Laboratory.

MM. Again on November 23, 1998, the patient was seen by the respondent for heartburn and gassiness. There was also an added complaint of sneezing. Respondent diagnosed acute allergic rhinitis, inhalant allergy, acute distal esophagitis, and acute GERD. The patient was treated with injections of Benadryl and Traimcinolone. Respondent also prescribed Allegra D and told the patient to continue thepriolsec and Biaxin.

NN. On December 4, 1998, the patient's complaints included coughing and chest congestion. There was also a follow up on the patient's heartburn and "blood test reports." Examination was normal except for "nodes" of the neck and epigastric tenderness. Vital signs were normal. Lung examination was normal. Diagnosis included acute GERD, acute diffuse gastroduodenitis, acute bronchitis, and acute pneumonitis. Treatment included an injection of Ancef (an antibiotic) and a course of Amoxil.

OO. On December 16, 1998, the patient was again seen for continued heartburn and reflux symptoms. A complaint of cough was included in this visit. Vital signs were normal and examination again noted "nodes" of the neck. Lung signs were normal. The respondent made a diagnosis of peptic ulcer disease (PUD), GERD, and acute bronchitis. Treatment included a prescription for Prilosec and lifestyle changes. A "comprehensive blood test" was ordered. The results included abnormal liver function tests (LFT's) again with the SGPT greater than the SGOT. H. pylori titer was again negative.

PP. On December 30, 1998, the patient again presented to respondent's office with complaints of sore throat, coughing and chest tightness. Vital signs were normal. Examination was significant for red tonsils and pharynx as well as a presence of neck "nodes". Breath sounds were described as harsh and again with mucous rales. Diagnosis included acute tonsillitis, acute bronchitis, acute pneumonitis and PUD. Treatment included an injection of Ancef and a course of Zithromax (an oral antibiotic). Prilosec and Mylanta were to be continued.

QQ. In March 1999, the patient was seen by the respondent on three (3) occasions. Within these visits, the patient's complaints again included cough, chest congestion, gassiness, indigestion, heartburn, and/or weakness. The patient's vital signs were generally normal. The examination on March 15, 1999, was identical to the examination on December 30, 1998. The respondent made several diagnosis including, acute bronchitis, acute pneumonitis, PUD, possible gallstones, GERD, body weakness, and possible hypothyroidism.

On March 15, 1999, spirometry was again ordered and the results were normal. A repeat abdominal ultrasound was ordered. The patient was again treated with an injection of Ancef and a course of Amoxil. Prilosec and Mylanta were continued. On March 24, 1999, another abdominal ultrasound was ordered and reported normal.

On March 31, 1999, there was no mention of the history of anemia and no hemoglobin was ordered. Respondent ordered again diagnostic tests

including comprehensive blood tests, repeat H. pylori titer and thyroid studies. Again, the patient's LFT's were elevated and again the H. pylori titer was negative. Treatment included initiation of Cisapride (a motility agent which was used for GERD until it was taken off the market) and continuation of Prilosec.

RR. On April 7, 1999, the patient presented a new complaint of urinary frequency and burning. No sexual history was obtained or recorded. No inciting causes were elicited. No genital or prostate examination was performed. There is a handwritten notation of a urinalysis positive for white blood cells and nitrite, but there is no record of the urine being sent to the laboratory for study or culture. Respondent diagnosed PUD, GERD, acute cystitis (bladder infection). Treatment included an injection of Ancef and Macrobid (an antibiotic useful in the treatment of urinary tract infections).

SS. On April 14, 1999, the patient presented to the respondent with complaints of sore throat, coughing and congestion. Again vital signs were normal. Examination was significant for a red pharynx and neck "nodes." Respondent diagnosed acute tonsillitis, acute bronchitis, acute pneumonitis, and GERD. Again, treatment consisted of an injection of Ancef and a course of Amoxil.

TT. On April 19, 1999, the patient's complaints included coughing, chest congestion and heartburn. On this visit, additional family history of father with colon polyps was obtained. Vital signs were again normal. Examination again revealed harsh breathing sounds and "nodes" on the neck. No rectal examination or fecal blood testing was performed. The diagnosis included acute bronchitis, acute pneumonitis, PUD, and GERD. Treatment again included an injection of Ancef and a course of Amoxil. Without explanation, the patient was scheduled for a colonoscopy as well as a repeat upper endoscopy.

UU. On April 26, 1999, the patient complained of midsternal chest pain, heartburn and "dark colored" stools. Accompanying symptoms noted were constipation and diarrhea, as well as nausea and vomiting. On this visit, it was

documented that the patient's father may have had colon cancer. On examination, respondent found hemorrhoids and stool which was occult positive for blood. Diagnosis included PUD, GERD, rectal bleeding, and colorectal neoplasm, possible. A hemoglobin was checked with normal results. An order to "verify insurance coverage" for the upper endoscopy and colonoscopy was indicated in respondent's plan.

VV. On May 20, 1999, upper and lower endoscopies were performed. The findings included GERD, acute diffuse gastrodudoenitis, acute nonspecific colitis and rectal polyps. Biopsies showed benign gastric mucosa, chronic duodenitis and hyperplastic rectal polyp. There was no sign of malignancy. Laboratory results dated 5/20/99 was positive for Giardia lamblia, an enteric pathogen. There was no indication in the medial record that this was noted or treated.

WW. On August 10, 1999, the patient was again reported to have complaints of the abdomen including heartburn, flatulence, and irregular bowel movements. Treatment again included an injection of Ancef, a course of Flagyl (an antibiotic), and a course of Amoxil. The patient was again reminded to stop smoking and Prilosec was continued. There was no mention made of the positive Giardia test.

XX. On September 19, 1999, the patient still complained of heartburn. There were added complaints of urinary frequency and burning. However, no sexual history was obtained or recorded. No genital or prostate examination was performed or recorded . Treatment again included an injection of Ancef followed by a course of Macrobid.

YY. On October 2, 1999, there is continued complaint of heartburn. On this visit, abnormal liver function was also identified. Diagnosis included PUD, Anicteric Hepatitis, GERD, and body weakness. A hepatitis screen was ordered but the results are not in the patient's record. An abdominal ultrasound was again ordered but the result was not documented.

ZZ. On October 25, 1999, the patient reported same abdominal complaints. There is no documentation of complaints relating to the respiratory tract.

however, diagnosis included PUD, GERD, acute bronchitis and acute pneumonitis. Treatment included a course of Amoxil and continuation of Prilosec.

AAA. On December 3, 1999, the patient was again seen for cough, chest congestion and heartburn. Vital signs were normal. Examination again revealed harsh breathing sounds, neck "nodes" as well as mucous rales. Acute bronchitis, acute pneumonitis and PUD were again diagnosed. Treatment again included an injection of Ancef followed by a course of erythromycin (an oral antibiotic). The patient was advised again to stop smoking and respondent performed "check wall manipulation."

BBB. Respondent has subjected his license to discipline, in that considered singularly as well as collectively:

i) He repeatedly administered parenteral antibiotics to S.R. without medical rationale or justification.

ii) He routinely administered injections of Ancef to patient S.R. without medical rationale or justification.

iii) He repeatedly prescribed oral antibiotics to patient S.R. without proper medical rationale or justification.

iv) He failed to evaluate the etiology of patient S.R.'s recurrent urinary symptoms.

v) He failed to elicit patient S.R's sexual history given complaints of urinary frequency and burning.

vi) He failed to perform genital and prostate examinations given the complaints of urinary frequency and burning.

vii) He failed to address the positive Giardia study.

viii) He recommended a colonoscopy without medical rationale or documented medical justification.

vix) He failed to understand that cystitis is an unusual diagnosis for an adult male.

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x) He failed to order a hemogram on 7/25/98 and 3/31/99, despite the complaints of weakness with a history of anemia.

xi) His diagnosis of H. pylori gastritis was without medical justification, as well as the subsequent antibiotic prescription for treatment also was without medical justification. Also, respondent failed to understand the proper treatment for H. pylori.

xii) He failed to order serologic testing for viral hepatitis.

xiii) He failed to appropriately treat and/or address the the patient's abnormal liver enzymes.

xiv) He routinely used and/or ordered diagnostic testing on patient S.R. without medical justification or rationale.

xv) He repeatedly ordered tests after receiving normal studies.

xvi) He used a template system for record keeping which provides little opportunity for notation of unique data.

## SECOND CAUSE FOR DISCIPLINE

**(Repeated Negligent Acts)**

13. Respondent is subject to disciplinary action under section 2234, subdivision (c), in that he has committed repeated negligent acts in his care and treatment of patients. The circumstances are as follows:

Patient S.M.

A. Paragraph 12. subparagraphs (A)-(I), are incorporated by reference as if set forth in full.

B. Respondent has subjected his license to discipline in that:

i) On at least four (4) occasions, he altered or otherwise modified without explanation the medical records of patient S.M. in areas such as examination findings, vital signs, and treatment plans;

ii) He routinely administered injections of Ampicillin to patient

S.M. without documented medical rationale or justification;

iii) He repeatedly uses vague and non-medical diagnoses such as "body weakness" which are unsupported by his charted findings; and

iv) He bills excessively for the services he performs.

Patient L.M.

C. Paragraph 12, subparagraphs (K)-(O), are incorporated by reference as if set forth in full.

D. Respondent has subjected his license to discipline in that:

i) On at least five (5) occasions, he altered or otherwise modified without explanation the medical records of patient L.M. in areas such as examination findings and treatment plans;

ii) He routinely administered injections of antibiotics to patient L.M. without documented medical rationale or justification;

iii) He routinely ordered and/or performed diagnostic testing on this patient without documented medical rationale or justification;

iv) He repeatedly uses vague and non-medical diagnoses such as "body weakness" which are unsupported by his charted findings; and

v) He bills excessively for the services he performs.

Patient C.C.

E. Paragraph 12, subparagraphs (Q)-(DD), are incorporated by reference as if set forth in full.

F. Respondent has subjected his license to discipline in that:

i) On at least eleven (11) occasions, he altered or otherwise modified without explanation the medical records of patient C.C.;

ii) He routinely administered injections of antibiotics and hormones to patient C.C. allegedly upon her request, without documented medical rationale or justification;

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iii) He routinely ordered and/or performed diagnostic testing on this patient without documented medical rationale or justification;

iv) He repeatedly uses vague and non-medical diagnoses such as "body weakness" which are unsupported by his charted findings; and

v) He bills excessively for the services he performs.

Patient S.R.

G. Paragraph 12, subparagraphs (GG)-(AAA), are incorporated by reference as if set forth in full.

H: Respondent has subjected his license to discipline in that:

i) He repeatedly administered parenteral antibiotics to S.R. without medical rationale or justification.

ii) He routinely administered injections of Ancef to patient S.R. without medical rationale or justification.

iii) He repeatedly prescribed oral antibiotics to patient S.R. without proper medical rationale or justification.

iv) He failed to evaluate the etiology of patient S.R.'s recurrent urinary symptoms.

v) He failed to elicit patient S.R's sexual history given complaints of urinary frequency and burning.

vi) He failed to perform genital and prostate examinations given the complaints of urinary frequency and burning.

vii) He failed to address the positive Giardia study.

viii) He recommended a colonoscopy without medical rationale or documented medical justification.

vix) He failed to understand that cystitis is an unusual diagnosis for an adult male.

x) He failed to order a hemogram on 7/25/98 and 3/31/99, despite the complaints of weakness with a history of anemia.

xi) His diagnosis of H. pylori gastritis was without medical justification, as well as the subsequent antibiotic prescription for treatment also was without medical justification. Also, respondent failed to understand the proper treatment for H. pylori.

xii) He failed to order serologic testing for viral hepatitis.

xiii) He failed to appropriately treat and/or address the the patient's abnormal liver enzymes.

xiv) He routinely used and/or ordered diagnostic testing on patient S.R. without medical justification or rationale.

xv) He repeatedly ordered tests after receiving normal studies.

xvi) He used a template system for record keeping which provides little opportunity for notation of unique data.

## THIRD CAUSE FOR DISCIPLINE

**(Incompetence)**

14. Respondent is subject to disciplinary action under section 2234, subdivision (d), in that he committed acts of incompetence in his care and treatment of patients. The circumstances are as follows:

A. Paragraph 12, subparagraphs (A)-(BBB), are incorporated by reference as if set forth in full.

B. Paragraph 13, subparagraphs (A)-(H), are incorporated by reference as if set forth in full.

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## FOURTH CAUSE FOR DISCIPLINE

**(Excessive Treatment)**

15. Respondent is subject to disciplinary action under section 725 in that he has committed repeated acts of clearly excessive treatment, diagnostic testing and prescribing. The circumstances are as follows:

A. Paragraph 12, subparagraphs (A)-(BBB), are incorporated by reference as if set forth in full.

B. Paragraph 13, subparagraphs (A)-(H), are incorporated by reference as if set forth in full.

## FIFTH CAUSE FOR DISCIPLINE

**(Dishonest Acts)**

16. Respondent is subject to disciplinary action under section 2234, subdivision (e), in that he has committed dishonest acts which are substantially related to the qualifications, functions, and duties of a physician and surgeon. The circumstances are as follows:

A. Paragraph 12, subparagraphs (A)-(EE), are incorporated by reference as if set forth in full.

B. Paragraph 13, subparagraphs (A)-(F), are incorporated by reference as if set forth in full.

## SIXTH CAUSE FOR DISCIPLINE

**(Making False Documents)**

17. Respondent is subject to disciplinary action under section 2261 in that he has knowingly signed medical documents which falsely represents the existence or nonexistence of a state of facts. The circumstances are as follows:

A. Paragraph 12, subparagraphs (A)-(EE), are incorporated by reference as if set forth in full.

B. Paragraph 13, subparagraphs (A)-(F), are incorporated by reference as if set forth in full.

**SEVENTH CAUSE FOR DISCIPLINE**

**(Alteration of Medical Records)**

18. Respondent is subject to disciplinary action under section 2262 in that he altered and/or modified medical records with fraudulent intent. The circumstances are as follows:

A. Paragraph 12, subparagraphs (A)-(EE), are incorporated by reference as if set forth in full.

B. Paragraph 13, subparagraphs (A)-(F), are incorporated by reference as if set forth in full.

**EIGHTH CAUSE FOR DISCIPLINE**

**(Inadequate Maintenance of Records)**

19. Respondent is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate and accurate records relating to the his care, management and treatment of his patients. The circumstances are as follows:

A. Paragraph 12, subparagraphs (A-BBB), are incorporated herein by reference as if set forth in full.

B. Respondent failed to properly document the examination, assessment and/or treatment of each patient's complaints and/or follow up.

C. Respondent failed to properly document medical justification and/or follow up of diagnostic test(s) or treatment plan(s).

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## DISCIPLINE CONSIDERATIONS

20. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges the following circumstances:

A. In 1987, Respondent was convicted of medicaid fraud in Lousiana.

B. On or about May 6, 1991, the Louisiana Medical Board/Examiners revoked respondent's medical license based on his criminal conviction.

C. On or about February 12, 1992, the Ohio Medical Board issued a permanent revocation of respondent's Ohio Medical Doctor License number 35- 37295, based on respondent's 1987 medical insurance fraud conviction in Lousiana and license revocation by the Louisiana Medical Board/Examiners. The revocation was effective on February 14, 1992.

D. On or about October 26, 1992, an Accusation was filed against respondent entitled, In the Matter of the Accusation Against Antonio A. Romero, M.D., before the Medical Board of California, Case Number D-5002. On December 8, 1994, respondent's license was issued a public reprimand based on respondent's criminal conviction for medical insurance fraud in Louisiana in 1987. That decision is now final and is incorporated by reference as if fully set forth.

## PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Division of Medical Quality issue a decision:

A. Revoking or suspending Physician and Surgeon's Certificate Number A34298, issued to Antonio A. Romero, M.D.;

B. Revoking, suspending or denying approval of Antonio A. Romero, M.D.'s authority to supervise physician's assistants, pursuant to section 3527 of the Code;

C. Ordering Antonio A. Romero, M.D. to pay the Division of Medical Quality the reasonable costs of the investigation and enforcement of this case, and, if placed on probation, the costs of probation monitoring;

D. Taking such other and further action as the Division of Medical Quality deems necessary and proper.

DATED: June 8, 2001

RON JOSEPH
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant